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MEDICAID BULLETIN

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Hospital Inpatient and Outpatient Rates and Hospital Lump Sum Reimbursement for Disproportionate Share Hospitals and Graduate Medical Education, Effective July 1, 2019

The purpose of this bulletin is to inform providers of changes in inpatient and outpatient rates for acute, rehabilitation, and freestanding psychiatric hospitals and to notify hospitals about lump sum payments for Disproportionate Share Hospitals (DSH) and graduate medical education.

DMAS is required to rebase hospital rates at least every three years (including State Fiscal Year (FY) 20). The following sections provide detail on the rebasing for inpatient and outpatient hospital rates as well as freestanding rehabilitation and psychiatric facilities.

Inpatient Reimbursement Rebasing

Acute hospital inpatient reimbursement rate parameters have been rebased according to 12VAC3070-391. For Type Two hospitals, the new base rates should result in total expenditures that reimburse on average 78% of acute and rehabilitation operating costs and 84% of psychiatric operating costs in the base year. For Type One hospitals, the cost percentage reflects the Type Two hospital statewide Diagnosis-Related Group (DRG) rate (62.6%).

The calculation of the new rate parameters utilized both fee-for-service (FFS) and MCO claim experience. Rates are adjusted by geographic regions using Medicare wage adjustment factors; rural hospitals use the wage adjustment factors of the nearest urban area.

In accordance with 12VAC 30-70-221(D), DMAS will implement version 35 of the 3M All-Patient Refined Diagnosis-Related Group (APR-DRG) grouper effective July 1, 2019. The rebasing work developed APR-DRG weights for each APR-DRG group and severity level using Virginia-specific data. The Virginia-specific DRG weights as well as other inpatient reimbursement parameters are available on the DMAS web site at www.dmas.virginia.gov. Click on “For Providers, Information for Providers, Rate Setting Information, Hospital Rates.” The new rate parameters will be effective for claims with dates of service on or after July 1, 2019.

Inpatient Hospital Capital Reimbursement

In accordance with 12VAC 30-70-271, inpatient capital percentage rates reflect 71% of cost for Type Two hospitals (75% for CHKD) and 96% of cost for Type One hospitals. The new capital percentages will be effective for claims with dates of service on or after July 1, 2019, and are available from the DMAS website.

Outpatient Reimbursement Rebasing

In accordance with 12VAC30-80-36(B), DMAS established new outpatient hospital weights and base rates and will incorporate an updated version of the Enhanced Ambulatory Patient Group (EAPG) grouper, effective July 1, 2019. DMAS began reimbursing Outpatient Hospital facilities in accordance with the EAPG reimbursement methodology on claims with dates of service beginning January 1, 2014. (See the Medicaid Memorandum dated November 8, 2013, "Enhanced Ambulatory Patient Group (EAPG) for Outpatient Hospital Services.")

DMAS is rebasing outpatient hospital base rates and implementing the EAPG grouper version 3.13 software, including the national weights developed by 3M with modifications for series billed claims. This action is in accordance with 12VAC 30-80-36(D). The new base rates will result in total expenditures that reimburse on average 76% of cost in the base year adjusting for emergency room triage claims and the DMAS lab fee schedule. The calculation of the new base rates reflects both FFS and MCO claim experience. Rates are adjusted by geographic regions using Medicare wage adjustment factors; rural hospitals use the wage adjustment factors of the nearest urban area.

The new EAPG weights and base rates are available on the DMAS web site at www.dmas.virginia.gov. Click the following links: For Providers, Provider Information, Rate Setting Information, Outpatient Hospital EAPG. The new EAPG weights and base rates will be effective for claims with dates of service on or after July 1, 2019.

Freestanding Rehabilitation and Psychiatric Hospital Rebasing

Freestanding rehabilitation hospital per diem rates have been rebased in accordance with 12VAC30-70-321. Freestanding psychiatric hospital per diem rates have been rebased in accordance with 12VAC30-70-415. Freestanding psychiatric hospitals should reimburse 100% of operating costs in the base year. Rates for these providers are available on the DMAS web site at www.dmas.virginia.gov. Click on For Providers, Information for Providers, Rate Setting Information, Hospital Rates.

Critical Access Hospital Rate Adjustment

In accordance with Item 303.ZZZ of the 2019 Acts of Assembly, DMAS adjusted acute hospital rates for critical access hospitals by using a percent of cost reimbursement of 100% for inpatient operating and capital rates as well as outpatient rates effective July 1, 2019.

Hospital Inflation

Final inflation used to adjust hospital rates for FY20 was 2.9%. When inflating hospital base year costs from FY17 to FY20, DMAS used no inflation adjustment in FY18, 2.9% inflation for FY19 and 2.9% inflation for FY20 as required by the 2019 Acts of Assembly. DSH, Indirect Medical Education, and Graduate Medical Education (GME) payments include the inflation adjustment for FY20.

Quarterly Lump Sum Reimbursement: DSH/IME/GME

Payment of the Disproportionate Share Hospital (DSH) adjustment, Indirect Medical Education (IME), and Graduate Medical Education (GME) is separate from inpatient and outpatient claim payments. In accordance with regulation, these payments reflect the 2.9% inflation adjustment for FY20. Payments are made as lump sum amounts at the end of each quarter. Payments for the fourth quarter will be made at the beginning of the next state fiscal year.

Lump sum payment amounts will be posted to the DMAS website no later than July 15, 2019 for Type Two hospitals. Lump sum payment amounts for Type One hospitals will be posted no later than September 30, 2019.

Disproportionate Share Hospitals (DSH)

In accordance with 12VAC 30-70-301, DSH payments are fully prospective amounts determined in advance of the state fiscal year to which they apply and are not subject to revision except for the application of limitations determined at cost settlement. In addition to meeting the 14% Medicaid utilization requirement in the base year (i.e., cost reports with providers' fiscal year ending in FY17), DSH hospitals must also meet the obstetric staff requirements or one of the regulatory exceptions. Any DSH hospital that eliminates obstetric services should promptly notify DMAS.

Indirect Medical Education (IME) and Graduate Medical Education (GME)

In accordance with 12VAC 30-70-291, prospective IME percentages for FY20 have been calculated using the most recent resident and intern to bed ratios. IME payments will be cost settled based on the hospital's FFS and MCO operating costs. Payment Prospective IME percentages and the estimated annual IME payments will be available from the DMAS website.

In accordance with 12VAC 30-70-281, GME costs for interns and residents are reimbursed on a per resident basis for Type Two hospitals. The annual interim GME payment reflects the most recently available hospital-reported number of interns and residents along with estimated nursing and paramedical education costs. GME payments for interns and residents will be settled based on the actual number of full-time equivalent (FTE) interns and residents as reported on the hospital's annual cost report. Type One hospitals are reimbursed cost for interns and residents. GME payments for nursing and paramedical education costs will be

cost settled. Estimated GME payments will be available from the DMAS website.

In accordance with Item 303.EEE(8) of the 2019 Virginia Appropriations Act, all hospitals that qualify for GME lump sum payments must provide information regarding the number and specialty/subspecialty of interns and residents. GME hospitals will receive a letter specifying the required data elements and formats by July 15, 2019. This submission is in addition to the intern and resident FTE information required for the hospital cost report and is due to DMAS by September 15, 2019.

Primary Care and High-Need Specialty Residents for Underserved Areas

In accordance with Item 303.EEE(4c) of the 2019 Virginia Appropriations Act, DMAS will make 19 awards for new residency payments for twelve (12) primary care and seven (7) high need specialty residents beginning in FY20. In addition, DMAS will award two one-year fellowships for addiction medicine. In accordance with Item 303.EEE(2), hospitals will receive $100,000 per new resident per year up to four years in addition to other graduate medical education funding. Hospitals awarded funding for primary care and high-need specialty residencies must certify that they have filled the new residency slots and that they are receiving no Medicare funding. Hospitals with residency programs that began in FY18 and FY19 must certify that the residency programs continue to meet DMAS requirements by June 1, 2019.

Payments follow the same quarterly schedule as other lump sum payments. Payments for residency programs that began in FY18 and 19 will continue until the residency ends (i.e., three or four years, depending upon the program of study). Forms and application information for 25 new residency slots for FY21 will be available from the DMAS Rate Setting website by July 8, 2019. Applications for the new residencies are due September 2, 2019.

If you have any questions, please contact Beth Jones at (804)298-3864 or email Beth.Jones@dmas.virginia.gov.

Medicaid Expansion

New adult coverage begins January 1, 2019. Providers will use the same web portal and enrollment verification processes in place today to verify Medicaid expansion coverage. In ARS, individuals eligible in the Medicaid expansion covered group will be shown as “MEDICAID EXP.” If the individual is enrolled in managed care, the “MEDICAID EXP” segment will be shown as well as the managed care segment, “MED4” (Medallion 4.0), or “CCCP” (CCC Plus). Additional Medicaid expansion resources for providers can be found on the DMAS Medicaid Expansion webpage at: http://www.dmas.virginia.gov/#/medex.

PROVIDER CONTACT INFORMATION & RESOURCES

Virginia Medicaid Web Portal Automated Response System (ARS) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	www.virginiamedicaid.dmas.virginia.gov
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
KEPRO Service authorization information for fee-forservice members.	https://dmas.kepro.com/
Managed Care Programs Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.	
Medallion 4.0	http://www.dmas.virginia.gov/#/med4
CCC Plus	http://www.dmas.virginia.gov/#/cccplus
PACE	http://www.dmas.virginia.gov/#/longtermprograms
Magellan Behavioral Health Behavioral Health Services Administrator, check eligibility, claim status, service limits, and service authorizations for fee-for-service members.	www.MagellanHealth.com/Provider For credentialing and behavioral health service information, visit: www.magellanofvirginia.com, email: VAProviderQuestions@MagellanHealth.com,or call: 1-800-424-4046
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627